GLOBAL PODIATRY PARTNERS
WORLD-CLASS FOOT & ANKLE SURGEONS

Patient Name:		
Last name	First name	M.I.
Desired name:	Date of Birth: / /	Age:
Social Security Number: - -		
Email address:		
Mailing address:		
Street/P.O. Box	City	
State	Zip code	
Email Address (if we can we email you newsletters and appointment reminders):		
Home Phone:	Cell Phone:	**Best Contact #:**
Emergency Contact Person:	Phone #:	
Gender: **Male☐ Female☐**	Marital Status: **Single☐ Married☐ Widowed☐ Separated☐ Divorced☐**	
Who do you authorize us to release/discuss your medical information to? **Name:**		
Primary Care Physician:	Date of last visit: / /	
How did you hear about us? **WEB☐ PCP (name:) FRIEND (name:) INSURANCE☐**		
****PLEASE TELL US WHO REFERRED YOU TO OUR PRACTICE SO WE CAN THANK THEM.****		
Employer:	Position:	Phone:
Preferred Pharmacy:		

Insurance Information

Name of Insured (if not patient);	
Relationship to Patient:	Employer:
Date of Birth:	Occupation:
Social Security Number:	Work Phone:

Workers Compensation Case

Claim #:	Case Manager:	Phone:
Workplace Contact Name:	Position/Title:	Phone:
Date last worked:	Are you working now?	

****Insurance & Payment Policy****

It can be very difficult for the average person to understand their insurance plan. Also, many insurance plans are changing. Unfortunately, there are hundreds of different insurance plans and almost all of them have their own rules. There is little consistency from company to company or even among different plans offered by the same company. The need for referrals, deductibles, copays, prior authorization, in network, out of network differs from insurance plan to insurance plan. It is in your best interest to find out your coverage before you arrive at the office for your appointment. No one likes to be surprised by their bill after being seen.

In 2016, **INSURANCE/MEDICARE DOES NOT COVER TRIMMING OF NAILS, CORNS, AND CALLUSES.** Please ask your insurance company if your are covered. You will have to pay for the service at the time of the visit.

Patients are financially responsible for all charges to their account
Patients are responsible for insurance referrals

****CREDIT CARDS-** If you use a credit/debit card, we may have to pass on a processing fee determined by your bank. Thank you!

Global Podiatry Partners, Inc

Santa Anita Medial Plaza 626-821-9323

Medical History

Chief Concern/Present Illness:

What is your present foot problem?

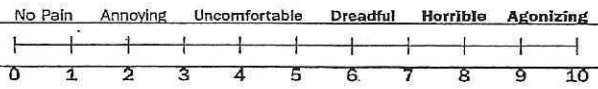
If due to injury, give date and details:

How long have you been bothered by the above?

What have you done for your foot problem? Padding ☐ NSAID's ☐ Altered shoe wear ☐ X-rays ☐
Soaks ☐ Altered Activity ☐ Physical Therapy ☐ Injections ☐ Shoe Inserts ☐ Surgery ☐
Topical Medications ☐

Have you had previous foot care/surgery? If so, by whom?

On a scale of 0-10, what is your pain level?



Medical History:

Are you now or have you ever been under a physician's care during the past two years? YES ☐ No ☐

Date of last complete physical exam: / /

Are you allergic to any medications? *** (Circle all that apply)***

No Known Drug Allergies	Adhesive Tape	Amoxicillin	Aspirin	Augmentin
Betadine	Codeine	Demerol	Erythromycin	Ibuprofen
Iodine	Keflex	Latex	Morphine	NSAIDs
Penicillin	Sulfa Drugs	Tylenol	Novocaine	Antihistamines
Other (list to the right):				

Medications: *Are you presently taking any medications?* Yes ☐ No ☐

List medications below:

Past Medical History: (Circle if you now have or were ever treated for)

AIDS/ARC	Circulation Disorders	High Blood Pressure	Rheumatic Fever
Allergies	Diabetes (insulin **or** non-insulin dependent)	Kidney Disease	Stomach Ulcer
Anemia	Epilepsy	Leg Cramps	Stroke
Anesthesia Problems	Glaucoma	Liver Trouble	Tuberculosis
Arthritis	Gout	Mental Health Conditions	Ulcers
Asthma	Heart Disease-Type ( )	Mitral Valve Prolapse	Venereal Disease
Bleeding Tendency	Heart Murmur	Polio	
Cancer – Type ( )	Hepatitis-Type ( )	Previous Foot Condition	

Global Podiatry Partners, Inc

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Medical History cont.

Have you ever had surgery? ☐ YES ☐ NO

List type of Surgery below	Year		Year
1.		5.	
2.		6.	
3.		7.	
4.		8.	

Family History: (Circle if any blood relatives have had)

Arthritis	Cancer	Diabetes	Heart Disease
High Blood Pressure	Kidney Disease	Overweight	Other: (list below)

Foot problems similar to yours? Mother ☐ Father ☐ Siblings ☐

Social History:

Use of Alcohol: Never ☐ Rarely ☐ Moderate ☐ Daily ☐

Use of Tobacco: Never ☐ Previously but **quit** (date:) Current packs/day ☐

Use of Drugs: Never ☐ Type/Frequency ( )

Review of Systems: (Please indicate current health status below by **circling** existing conditions)

Constitutional Symptoms	Gastrointestinal	Integumentary (skin)	Psychiatric
Good general Health lately	Loss of Appetite	Rash or itching	Blurred or double vision
Recent weight change	Nausea or vomiting	Change in skin color	Memory loss or confusion
Fever	Frequent diarrhea	Change in hair or nails	Depression
Fatigue	**Genitourinary**	Varicose veins	Insomnia
Eyes	Kidney Disease	Dry skin	**Endocrine**
Eye disease or injury	Dialysis	**Neurological**	Diabetes
Wear glasses/contact lenses	Kidney Stones	Frequent or recurring headaches	Glandular or hormone problem
Cardiovascular	**Musculoskeletal**	Light headed or dizzy	Excessive thirst or urination
Chest pain or angina pectoris	Joint pain	Convulsions or seizures	Heat or cold intolerance
Shortness of breath	Joint Stiffness or swelling	Numbness or tingling sensations	**Hematologic/Lymphatic**
Swelling of feet, ankles or hands	Weakness in muscles or joints	Tremors	Slow to heal after cuts
Respiratory	Muscle pain or cramps	Paralysis	Bleeding or bruising tendency
Chronic or Frequent coughs	Back pain	Head injury	Anemia
Spitting up blood	Cold Extremities	Stroke	Phlebitis
Shortness of breath	Difficulty in walking		Past transfusion
Wheezing	Neuromuscular disease		

Shoe Size: ( )

Office use only below

I have reviewed with the patient the complete history provided: **X** / /

Wenjay Sung, DPM, FACFAS Date

Thank you for your cooperation!

GLOBAL PODIATRY PARTNERS
WORLD-CLASS FOOT & ANKLE SURGEONS

Patient name: _____ **DOB:** _____

Financial Policy

Thank you for choosing Global Podiatry Partners, Inc. as your healthcare provider. We are pleased to be able to render services in the evaluation and treatment of your condition. Please understand that you will be financially responsible for charges that are not covered by your insurance. Your clear understanding of our Financial Policy is important to our professional relationship.

We need a current copy of your insurance card in order to bill your insurance direct for the charges and services rendered. If you do not provide us with a current insurance card or do not have insurance, full payment is due at the time of service. We accept cash, check or credit/debit card. Please notify us immediately if there are any changes to your insurance plan or your coverage. Co-payments and deductibles are an arrangement between you and your insurance plan, are your responsibility, and are not something we can negotiate. Co-payments are due at the time of service and charges to cover your deductible may be requested to be paid towards if it has not been satisfied. Medical records or copies of records can be provided at your request; please allow up to 5 business days for records to be compiled. There may be a nominal fee for record copying.

SELF-PAY: We expect full payment at the time of service unless prior arrangements have been made.

MEDICARE: We accept Medicare assignment. There are some services that are not covered by Medicare. We will advise you if there are any non-covered charges prior to that service provided.

HMO/PPO: We are providers for many insurance plans, but not all plans. You are responsible for verifying that we are providers for your plan. If you are an HMO member, you must have a current referral at the time of your visit in order to be seen, and for the visit to be covered under your plan. Without a proper referral, you may be responsible for charges incurred. If you are a PPO member, you are responsible for co-payments, deducible, and co-insurance. Please confirm with your insurance that we are providers covered under your plan.

WORKERS' COMPENSATION: If you are consulting with is regarding a work-related injury, we require information for both your personal coverage as well as your employer's Workers' Compensation insurance. Prior to being evaluated in our office, we need to have a letter or statement from your Workers' Compensation carrier authorizing you treatment. The letter should include the claim number, date of injury, address, adjuster's name and phone number. Your employer's human resourced office should be able to assist you with obtaining this information. If payment is not received from these third parties within 90 days, we reserve the right to bill you directly.

HOSPITAL & SURGERY CENTER CHARGES: In the event that you undergo surgery on a hospital or outpatient surgery center, separate charges will be made by the facility and/or anesthesiologist. Please contact the hospital or surgery center for billing inquiries.

USR (USUAL & CUSTOMARY RATES): We are committed to provide the best treatments possible for our patients. Our fees for services rendered are usual and customary for our geographic area. If we do not have a contract with your insurance company, you are responsible for payment in full regardless of any insurance companies' arbitrary determination of UCR rates.

****I understand that I am financially responsible for all charges not covered by my insurance. I guarantee that the balance will be paid by cash, check or credit card. Past due balances may be subject to additional fees. I understand that if the office agrees to bill insurance as a courtesy, I must submit information as needed in a timely manner, to ensure that payment for services rendered. I understand that I am ultimately responsible for all serviced rendered.**

Signature of Patient/Guardian X _____ **Date:** _____

Appointment of Authorized Representative:

****I hereby appoint Global Podiatry Partners, Inc. to act on my behalf as an authorized representative with respect to all matters related to requests for authorization and claims for services rendered by Global Podiatry Partners, Inc. This includes, but is not limited to, requests for and receipt of any approvals and authorizations that are required before medical services, the right to request and file appeals on my behalf, and the right to obtain payment for covered items and services furnished to me. I further authorize my representative to receive any and all information that is provided to me with respect to requests for authorization and claims for services furnished by Global Podiatry Partners, Inc.**

Signature of Member/Guardian X _____ **Date:** _____

Member ID # _____ **Address:** _____ **Phone:** _____

We, Global Podiatry Partners, Inc., hereby accept the above appointment.

GLOBAL PODIATRY PARTNERS
WORLD-CLASS FOOT & ANKLE SURGEONS

Patient Name : _____ **DOB:** _____

Authorization for treatment, assignment, and release:

I hereby give Global Podiatry Partners, Inc. and its staff members permission to treat my foot and/or ankle disorders. I, the undersigned, have insurance coverage and assign directly to Global Podiatry Partners, Inc. all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charged whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions.

Signature Patient/Guardian X _____ **Date:** _____

MEDICARE/INSURANCE Authorization:

I request that payment of authorized Medicare and/or insurance benefits be made either to me or on my behalf to Global Podiatry Partners, Inc. for any services furnished to me by that physician. I authorize any holder of medical information about me to release the Health Care Financing Administration and its agents any information needed to determine these benefits payable for related services. I understand my signature requests that payment be made and authorized release of medical information necessary to pay the claim. If "other health insurance" is indicated in the item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agreed to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

Signature of Insured/Guardian X _____ **Date:** _____

Notice of Privacy Practices:

I hereby acknowledge I have read and understand the Notice of Privacy Practices that is posted in the reception area, and a copy will be made available to me upon request.

Signature of Patient/Guardian X _____ **Date:** _____

Telehealth Acknowledgement:

I understand that (1) Global Podiatry Partners, Inc. has recommended to me that I engage in telehealth appointment. (2)Global Podiatry Partners has explained how the telehealth technology will be use to connect me with a provider. Telehealth appointments may be conducted by videoconferencing, video/still images, or by telephone. I understand that telehealth will not be the same as a direct patient/healthcare provider visit due to the fact that I will not be in the same room as my healthcare provider. (3)There are potential risks to this technology, including interruptions, unauthorized access, and technical difficulties. My healthcare provider or I can discontinue the telehealth appointment if it is felt that the connections are not adequate for the situation. I can discontinue the appointment at any time. (4)My healthcare information may be shared with other individuals for scheduling/billing purposes. Others may be present during the appointment other than my healthcare provider in order to operate equipment. The above mentioned people will all maintain confidentiality of the information obtained. I will be informed of the presence during the consultation and will have the right to request the following: (a)omit specific details of my medical history/physical exam that are personally sensitive; (b)ask non-medical personnel to leave the room; (c)terminate the telehealth appointment at any time. (5)In an emergency situation, I understand that the responsibility of the provider may be to direct me to emergency medical services, such as the emergency room. The provider may discuss with and advise my local provider. The provider's responsibility will end upon the termination of the telehealth connection. (6)Billing for the telehealth consultation may occur from: (a)the primary care provider, (b)telehealth provider, and (c)as a facility fee from the site from which I am presented. Billing will be at the discretion of the provider. Billing procedures will be explained to me. (7)I understand the risks and the benefits of telehealth and I hereby consent to participate in a telehealth appointment visit under the terms described herein.

Signature Patient/Guardian X _____ **Date:** _____

Medical Records Release:

I authorize the release of my medical records or other pertaining health care information, including intake forms, chart notes, operative/lab/radiology reports, and other written information concerning my health and treatment to Global Podiatry Partners, Inc.

Signature of Patient/Guardian X _____ **Date:** _____